KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

INSTRUCTOR APPLICATION FOR CNA, CMA AND HHA TRAINING COURSES

Mark type of course. G Nurse Aide Curriculum G Home Health Aide Curriculum G Medication Aide Curriculum

KDADS OFFICE USE ONLY

Instructor ID #_____ CNA Approval Date____-____-____ Disapproval Date____-____-

Reviewer Signature _____ CMA Approval Date____-____-____ Disapproval Date____-____-

HHA Approval Date____-____-____ Disapproval Date____-____-

Following approval, please use the six-digit Instructor ID# which has been assigned by the department. Include the assigned Instructor ID# on all future correspondence with the department.

Type or print in all information that is requested. This application should be received by this department at least three weeks prior to offering an initial nurse aide, home health aide or medication aide update training course.

APPLICANT, PLEASE NOTE: The attached CNA-CMA-HHA Instructor Employment Verification forms **must** be completed by current/former employer(s) for **each reference** listed on the application. All employment verifications must be received by Health Occupations Credentialing before the application can be processed.

Applicant Information

Name_____
First MI Last Other

Social Security Number___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth _____/_____/_____

Mailing Address_____
Street City State Zip

Home Address _____
Street City State Zip

Phone # (home) ( )_____ (work) ( )_____ CNA ID number (if applicable)?_____

E-mail address _____

Kansas Licensure # (LPN/RN) ___ ___/___ ___ ___ ___ ___ ___/___ ___ ___ Expiration Date ___-___
mm yr

Instructor Qualifications:

NURSE AIDE INSTRUCTOR:
According to state and federal standards, each course instructor must be a registered nurse with a current Kansas license and have a minimum of two years' licensed nursing experience. At least 1,750 hours must be as a licensed nurse in a setting which demonstrates long-term geriatric nursing care, such as an adult care home or a distinct-part long term care unit or a state institution for the mentally retarded. Additionally, all nurse aide instructors must have completed a course in teaching adults or a professional continuing education offering on supervision or adult education, or shall have experience in teaching adults or supervising nurse aides.

To document alternative long-term care setting: AAlternative Practice Setting Experience@ form is available upon request.

HOME HEALTH AIDE INSTRUCTOR:
According to state and federal standards, each instructor of a home health aide course must be a registered nurse with a current Kansas license and have direct work experience in the provision of home health care. In order to qualify as an approved instructor, the state requires that the candidate be a registered nurse with a minimum of two years= licensed nursing experience. At least 1,750 hours must be as a licensed nurse in home health care services.

To document alternative home health care setting: AAlternative Practice Setting Experience@ form is available upon request.

MEDICATION AIDE INSTRUCTOR:
Each instructor must be a registered nurse with a current Kansas license and have two years full-time clinical experience as a registered nurse.

Employment Information (**Licensed Nursing Experience**)
Please provide only the employment information on the following pages that directly demonstrates that you meet the instructor qualifications previously described. If additional space is needed, please follow the same format as this form. A resume may not be substituted for the information requested in this section.

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: ________________ (mm / dd / yr) To: ________________ (mm / dd / yr)		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides __________
Type of Work____________________________ Dispensed Medication ________
Employment Verification Attached ________

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: ________________ (mm / dd / yr) To: ________________ (mm / dd / yr)		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides _________
Type of Work____________________________ Dispensed Medication ________
Employment Verification Attached ________

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: ________________ (mm / dd / yr) To: ________________ (mm / dd / yr)		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides __________
Type of Work____________________________ Dispensed Medication __________
Employment Verification Attached ________

Adult Education Training Course

Training School Name	TRAINING COURSE IN ADULT EDUCATION OR A PROFESSIONAL CONTINUING EDUCATION COURSE ON SUPERVISION OR ADULT EDUCATION MAY BE DOCUMENTED BY SUBMISSION OF POST-SECONDARY TRANSCRIPT OR CERTIFICATE OF COMPLETION.
School Mailing Address	
Dates of Attendance From: _____ To: _____ mm/dd/yy mm/dd/yy	

NOTE: Course instructors and sponsors are responsible for being knowledgeable of and adhering to all pertinent statutes, regulations, policies or administrative guidelines in making application for course approval including but not limited to Kansas Statutes Annotated 39-926, Kansas Administrative Regulations 28-39-165 through 170, the Kansas 90-Hour Nurse Aide, Home Health Aide, or Medication Aide Curriculum Guidelines.

Signature of Applicant: I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments. I do hereby acknowledge that it is my responsibility to obtain employment verification from current/previous employer(s) for each reference listed on the application. I am fully aware that failure to provide this information to Health Occupations Credentialing will delay the processing of this application.

Signature _____ Date_____

Please complete all the employment information that demonstrates that you meet the instructor qualifications and attach the employment verification forms which have been completed by each employer and return to:

Health Occupations Credentialing
Kansas Department for Aging and Disability Services
612 S Kansas Ave
Topeka, KS 66603-3856

Phone number: (785) 296-1250
email address: betty.domer@kdads.ks.gov

KDADS OFFICE USE ONLY

CNA	Instructor # _____	Approval Date____-____-____	Disapproval Date____-____-
CMA	Instructor # _____	Approval Date____-____-____	Disapproval Date____-____-
HHA	Instructor # _____	Approval Date____-____-____	Disapproval Date____-____-

Reviewer Signature_____

Comments:

HEALTH OCCUPATIONS CREDENTIALING
612 S Kansas Ave
Topeka, KS 66603-3404

CNA-CMA-HHA INSTRUCTOR EMPLOYMENT VERIFICATION

APPLICANT: COMPLETE THIS SECTION
(Photocopy as needed and send to each employer listed on your application.)

Social Security Number _____-_____-_____ RN License Number _____/_____/_____

Name _____
(Last) (First) (M.I.)

Other Names Used _____

Address _____
(Street) (City/State) (Zip)

Phone Number (Home) _____ (Work) _____

By my signature, I authorize the release of employment verification from the facility named below to the Kansas Department of Health and Environment.

Signature _____ Date _____

EMPLOYER: COMPLETE THIS SECTION

Name of Facility _____ Telephone number (____)_____

Address _____

Type of facility: Adult Care Home _____ Hospital_____ Home Health Agency _____ Other (Explain) _____

Comments:

I certify that the individual named above is/was employed by me as an LPN or RN (Circle one)

from _____ to _____.

This individual was employed as a licensed nurse as follows **(number of hours per week must be included)**:

In an adult care home or distinct-part long term care unit from _____ to _____ Hours per week: _____

In home health care services from _____ to _____ Hours per week: _____

Other licensed nursing experience from _____ to _____ Hours per week: _____

Experience in administering medication _____Yes _____No

Please explain if other licensure setting _____

Signature _____ Date_____

Title _____